

Credit Card Payment Consent Form



Patient Name _____
Print Last First Middle Initial

Name on Card if different _____

I authorize _____, and **ProfessionalCharges.com**, to charge my credit/debit card for professional services as follows:

Type of Card: Visa, MasterCard, Discover.

Credit Card Number _____ - _____ - _____ - _____, CVV Number _____
A 3-digit number in reverse italics on the **back** of the credit card

Expiration Date _____

Card Holder's Billing Address for Credit Card Statements

Street _____ City _____ State _____ Zip _____

If I have questions about these charges, I agree to contact my provider and if necessary ProfessionalCharges.com via email (info@professionalcharges.com). I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

Card Holder Signature _____, Date ____/____/____

Charges will appear on your credit card statement as **ProfCharges.com** or some other abbreviation of **ProfessionalCharges.com**.

ProfessionalCharges.com
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